ZiaLogic

Innovative Strategies for Behavioral Health Systems

MONTANA CCISC IMPLEMENTATION PROJECT

ANNUAL REPORT: August 2007- October 2008

November, 2008

CCISC IMPLEMENTATION

I. INTEGRATED PLANNING AND IMPLEMENTATION STRUCTURE

Recommendations:

A. The structure, function, and activities of the AMDD Change Agents and Policy Team and the work and activities of all workgroups need to be regularly and proactively communicated as official communication to all key constituencies in the system.
B. Within AMDD, the involvement of Program Officers in this process can model the development of integrated implementation at the Division level. All staff, regardless of bureau affiliation, should see themselves as "co-occurring or integrated AMDD staff" members who are responsible for overseeing implementation of co-occurring standards within their work.
C. Within this framework, the role of the Community Program Officers (CPOs) in supporting co-occurring capability development and integrated partnerships in each community needs to be clearly defined and documented.
D. In addition, all AMDD staff could organize cross-bureau teams that will identify particular regions or communities as their purview. Each team member might start to develop relationships with ALL the programs in that particular region or community, and work collaboratively with each other to assist with co-occurring capability development. This will give a strong message to agency CEOs that AMDD is functioning as an integrated system.
E. In the same way, it might be helpful for there to be an integrated team that works with Montana State Hospital (MSH) and Montana Chemical Dependency Center (MCDC).
F. AMDD leadership has offered assistance to CMHB to learn about all the steps AMDD went through, and about all of the materials and processes that have been developed, in order for CMHB to organize its own change process. However, AMDD is not responsible for organizing what CMHB actually does.
G. CMHB should consider using the existing AMDD charter to develop a starting place for its own internal implementation team, and to develop a consensus on actions for its own provider system. Ideally, CMHB programs and Change

Agents will be able to join in existing processes, both locally and at the state level.

H. AMDD should begin to use its capacity to function as an "integrated internal team" to support consistent policy implementation strategies across all providers (see below), and, very importantly, to begin to develop and formalize integrated collaboration networks in each community or region. (See below).

II. INTEGRATED CONTINUOUS QUALITY IMPROVEMENT PROCESS

Recommendations:

A. AMDD is now in a position to organize the Change Agents and Policy Team to use the **CO-FIT 100™** to establish a current system measure for CCISC implementation, and then to organize system outcome measures based on that process.

B. **Continue to improve the collection of data to identify individuals with co-occurring needs within each data set (MH and CD).** It is important to reinforce the idea that the goal is not to track clients who are connected in two different systems, but rather to track the recognition of co-occurring individuals within each data set or funding stream, to support integrated (rather than parallel) service delivery.

C. **Identify simple mechanisms for collecting information on how effectively individuals with complex issues are being welcomed and engaged in care, and using that information to begin an improvement process.** For example, each local community could track each co-occurring person in crisis, for a limited period of time, to develop a baseline on "what happened". Who was welcomed and engaged, and who fell through the cracks? This should be set up in a way that is not about "criticizing" or about "fixing the problem". Then, AMDD staff can offer assistance to each community to craft an improvement process and track progress over time. A similar approach can be used to look at access and engagement back and forth between communities and the two institutions.

III. FUNDING PLAN

Recommendations:

A. Draft procedures for how to use each funding stream to support integrated service.

B. Identify one funding barrier to integrated access, and develop a set of instructions to improve access. For example, how can eligibility instructions be modified for individuals in severe crisis in order to facilitate access to care within existing resources, and thereby to reduce the risk of more expensive inpatient care.

C. Develop a set of policy guidelines that encourage mental health clinicians to provide, and bill for, consultation and intervention in substance abuse settings, and vice versa.

D. Connect financial awards and other available incentives for all providers to the extent to which they are demonstrating participation, and progress, in their quality improvement activities regarding co-occurring disorder capability.

IV. STRATEGIC ALIGNMENT

Recommendations:

A. Continue to engage the Change Agents and AMDD staff as a team to make presentations to SAAs, local community networks, and legislative committees.
B. Encourage the SAAs to make a recommendation to support CCISC system development in their regions and in their local communities, and to establish regular interagency **clinical meetings in each community. (See below).**

V. IMPLEMENTATION OF CO-OCCURRING CAPABLE PROGRAM STANDARDS

Recommendations:

A. The endorsement guidelines need to be embedded in all policy and contract language, including that which applies to direct operated services, including MSH and MCDC.
B. Existing regulations need to be reviewed to ensure elimination of inconsistencies with the endorsement guidelines.

VI. IMPLEMENTATION OF INTERPROGRAM AND INTERAGENCY PARTNERSHIPS

This area represents one of the highest priorities for activity at present.

Recommendations:

A. The first step is to build a structure to address this issue. One possibility is to identify a specific workgroup on community partnership, and to invite members who have had successful experiences to begin to work on this issue.
B. It should be an expectation that leaders of AMDD funded agencies meet regularly for the purpose of collaboration, and that a team of Change Agents meet regularly to address clinical and practice development.
C. Each local community should have access to AMDD staff to help to convene the meetings.
D. The statewide workgroup can be a place where input from the local groups is regularly reported, so that a learning community on integrated partnership and collaboration is developed**.**

VII. CLINICAL PRACTICE GUIDELINE DEVELOPMENT

Recommendations:

A. Within the statewide Change Agent and Policy Team, identify a workgroup that will focus on guidelines for integrated clinical practice documentation. The purpose of this group is to share successful strategies for creating routine clinical practice instructions that support the endorsement guidelines and are supported by legitimate documentation.
B. In the same process, review all existing "paperwork" or "practice" requirements to identify redundancies and inconsistencies with the clinical practice guidelines for integrated care. One issue that is frequently mentioned is the documentation

and re-documentation of the diagnosis of substance dependence, and the limitation of that documentation to certified addiction professionals.

VIII. WELCOMING, ACCESS, AND SCREENING

Recommendations:

A. The most important steps at this point are to begin to develop a system wide CQI process by which all providers are individually and collectively engaged in demonstrating improvement of welcoming and access within existing resources.
B. Consultation needs to be provided to EACH local system, along with specific assistance in how to create a problem solving partnership so that clients don't fall between the cracks.
C. It is possible to collect sample cases and to use them to illustrate how crisis clinicians can practice welcoming engagement. Most of the cases ZiaLogic has reviewed, as in the October training, were cases in which the clinicians, programs, and teams assumed that the "solution" was that the client needed a resource that was not available, when in fact the local system already had capacity to engage the client, but wasn't organized to think about how to use that capacity effectively.
D. AMDD needs to seek out opportunities to develop rules or guidelines for access that eliminate any arbitrary barriers based on co-morbid conditions being active.
E. With regard to screening, the next step is to help programs learn to document the results of positive screens into both clinical and administrative data, in order to track the client getting what he or she needs as a result of the screening. We recommend simple "yes", "no", "maybe" outcomes of screening, in order to determine who needs further integrated assessment and who needs integrated service.

IX. INTEGRATED SERVICE DELIVERY AND DOCUMENTATION

Recommendations:

A. See the recommendations on documentation in the Practice Guideline section.
B. Distribute a sample template for integrated stage matched treatment planning that clearly indicates the need for and expectation by AMDD for integrated documentation in each program. This template would indicate required elements of a treatment plan, while providing flexibility for providers regarding how to adapt it to their individual needs.

X. DEVELOPMENT OF CLINICIAN COMPETENCIES AND SCOPES OF PRACTICE

Recommendations:

A. AMDD needs to provide an approved list of core competencies that make this integrated scope of practice feel easily achievable for all staff.
B. AMDD needs to provide or ensure the provision of site-based training for agencies and program staff that have not been able to participate in organized training conferences and meetings.

C. Each agency needs a competency development plan regarding core clinical practices (welcoming, screening, integrated strength based assessment and case formulation, stage identification and stage matched intervention, skill building and use of skill manuals), based on the need for staff to engage in ongoing experiential supervised learning, rather than primarily outside training.
D. The Change Agents need continuing support from AMDD to ensure that every program has a clearly identified Change Agent, and that the Change Agents are engaged in working with their managers and staff, and are communicating with other Change Agents.
E. There needs to be clarity that AMDD is encouraging clinicians to routinely provide integrated services, and to use referral only when it is specifically needed. Clinicians should model the use of consultation as an alternative to parallel care: "For this client it would be better if you worked on his depressive issues along with his addiction, and I will provide you consultation, rather than having the client see both of us."

XI. COMPREHENSIVE ARRAY OF SERVICES

Recommendations:

A. Peer-oriented and operated services: One target for community based planning might be to concretely develop dual recovery meetings in each community.
B. PACT teams: It would be appropriate for PACT teams to use the IDDT fidelity tool to assess their development as enhanced co-occurring programs within the context of CCISC.
C. Crisis Services: Continuing to steadily develop a statewide safety net of co-occurring capable crisis response and intervention services are a high priority. Crisis facilities should serve a stepdown as well as a diversion function, and crisis response teams should provide ongoing crisis intervention, not just triage.
A. Investing in specific strategies to support the provision of expert co-occurring disorder consultation through a regional "telemedicine" approach may facilitate expansion of best practices, particularly in relation to psychopharmacologic strategies for addictive disorders, including buprenorphine.

CONCLUSION

AMDD has utilized the Policy Team, and the Change Agents, to make steady progress in the past year. This progress is particularly impressive in that Montana has not received any targeted grant funding to support this initiative, but is developing the change process entirely within its own resources. The engagement of the Children's Mental Health system in this process is very exciting, and demonstrates AMDD's ability to develop an effective partnership. We look forward to seeing continued progress as the process expands and becomes more firmly anchored into policy, procedure, and practice.

There are a number of areas in which ZiaLogic can offer consultative assistance in implementation of the above recommendations, primarily through off site activities such as teleconferencing, e-mail contact, and review of materials and documents. These areas are:

a. Assisting with the ongoing data improvement related to capturing the prevalence of comorbidity, through e-mail review of the data, and periodic phone consultation.
b. Assisting with the development and tracking of data indicators to support measurement of progress in welcoming and engagement.
c. Consulting on the development of the revised Charter Document.
d. Working on the development of billing instructions for integrated care.
e. Helping to develop financial incentives to support progress in individual agencies or in local communities.
f. Reviewing policies and contracts to make recommendations regarding aligning the endorsement guidelines with all regulatory language.
g. Providing templates for integrated practice documentation, and adapting existing materials to support integrated care.
h. Working with psychiatrists to help develop Montana specific psychopharmacology practice guidelines for treating people with co-occurring disorders.
i. Facilitating teleconferences between Change Agents in Montana, and potentially, between Montana Change Agents and Change Agents in other states.
j. Providing agency specific teleconferences for technical assistance on co-occurring disorder capability development.
k. Providing consultation to AMDD "integrated teams" regarding agency or community based consultation and technical assistance.
l. Providing teleconferences to local community networking groups regarding how to build collaboration for integrated systems, and to improve crisis safety net capacity.

We look forward to our continued collaboration with AMDD (and potentially CMHB) in building a welcoming integrated system of care for individuals and families with mental health and substance use disorders in Montana.

Respectfully submitted,

Christie A. Cline, MD, MBA, PC
President

Kenneth Minkoff, MD
Senior Systems Consultant